		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042663

Facility Name: SunBridge Care & Rehab - Effingham

Address: 1115 N. Wenthe (Number) Effingham (City) 62401 (Zip Code)

County: Effingham

Telephone Number: (217) 347-7121 **Fax #** (217) 347-5605

IDPA ID Number: 850370802-033

Date of Initial License for Current Owners: 6/5/97

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Sylvia Moreno **Telephone Number:** (505) 468-4984

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ 3/28/01 (Date)
(Type or Print Name) Dean Kiklis
(Title) Vice President of Reimbursement

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number SunBridge Care & Rehab - Effingham # 0042663 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds: No Bed Changes

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,586	11,268	4,361	34,215	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,586	11,268	4,361	34,215	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.12%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 6/1/97

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 6/1/97 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 24 and days of care provided 4,291

Medicare Intermediary TrailBlazer Health Enterprises LLC

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number SunBridge Care & Rehab - Effingham # 0042663 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	113,387	13,212	14,648	141,247	53,202	194,449	1,395	195,844			1
2	Food Purchase		131,617		131,617	19	131,636	(215)	131,421			2
3	Housekeeping	63,752	10,162	107,948	181,862	29,913	211,775		211,775			3
4	Laundry	34,208	10,714	219	45,141	16,051	61,192		61,192			4
5	Heat and Other Utilities							1,066	1,066			5
6	Maintenance	28,805	11,383	29,353	69,541	13,516	83,057	(5,107)	77,950			6
7	Other (specify):* Please See Attached											7
8	**TOTAL General Services**	240,152	177,088	152,168	569,408	112,701	682,109	(2,861)	679,248			8
	B. Health Care and Programs											
9	Medical Director			9,654	9,654	(22)	9,632		9,632			9
10	Nursing and Medical Records	1,076,275	190,922	64,887	1,332,084	506,011	1,838,095		1,838,095			10
10a	Therapy		4,445	367,073	371,518		371,518		371,518			10a
11	Activities	38,772	2,960		41,732	18,192	59,924		59,924			11
12	Social Services	37,141	132	6,196	43,469	17,427	60,896		60,896			12
13	Nurse Aide Training											13
14	Program Transportation							20	20			14
15	Other (specify):* Please See Attached											15
16	**TOTAL Health Care and Programs**	1,152,188	198,459	447,810	1,798,457	541,608	2,340,065	20	2,340,085			16
	C. General Administration											
17	Administrative	49,931		169,800	219,731	22,829	242,560	(77,587)	164,973			17
18	Directors Fees											18
19	Professional Services			1,027	1,027		1,027	6,874	7,901			19
20	Dues, Fees, Subscriptions & Promotions			9,421	9,421		9,421	(2,242)	7,179			20
21	Clerical & General Office Expenses	95,161	9,524	29,770	134,455	43,637	178,092	82,045	260,137			21
22	Employee Benefits & Payroll Taxes			592,489	592,489	(721,354)	(128,865)	139,079	10,214			22
23	Inservice Training & Education			325	325	(19)	306	96	402			23
24	Travel and Seminar			7,953	7,953		7,953	6,642	14,595			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			68,203	68,203		68,203	(63,448)	4,755			26
27	Other (specify):* Please See Attached			(9,762)	(9,762)		(9,762)	9,568	(194)			27
28	**TOTAL General Administration**	145,092	9,524	869,226	1,023,842	(654,907)	368,935	101,027	469,962			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,537,432	385,071	1,469,204	3,391,707	(598)	3,391,109	98,186	3,489,295			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number SunBridge Care & Rehab - Effingham #0042663 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			8,708	8,708		8,708	34,151	42,859			30
31	Amortization of Pre-Op. & Org.							10,117	10,117			31
32	Interest			2,787	2,787		2,787	8,189	10,976			32
33	Real Estate Taxes			26,310	26,310		26,310	180	26,490			33
34	Rent-Facility & Grounds			503,139	503,139		503,139	2,583	505,722			34
35	Rent-Equipment & Vehicles			20,591	20,591	598	21,189	5,720	26,909			35
36	Other (specify):* Please See Attached			495	495		495	11,932	12,427			36
37	**TOTAL Ownership**			562,030	562,030	598	562,628	72,872	635,500			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			24	24		24		24			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			74,720	74,720		74,720		74,720			42
43	Other (specify):* Please See Attache		3,956	5,613	9,569		9,569		9,569			43
44	**TOTAL Special Cost Centers**		3,956	80,357	84,313		84,313		84,313			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,537,432	389,027	2,111,591	4,038,050		4,038,050	171,058	4,209,108			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SunBridge Care & Rehab - Effingham # 0042663 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals		1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(15)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(215)	2		13
14	Non-Care Related Interest	(151)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,339)	20		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	18,024	27		24
25	Fund Raising, Advertising and Promotional	(495)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	6,102	29		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 20,911		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	150,147	SCH VII	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 150,147		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 171,058		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

SunBridge Care & Rehab - Effingham

ID# 0042663

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Employee Meals	$ 0		1
2	Rental Income	0		2
3	Personal Laundry Income	0		3
4	Rebates & Refunds	0		4
5	Sales Tax on food	0		5
6	Interest Income	0		6
7	Penalties and Late Fees	0		7
8	Contributions	0		8
9	Legal Services (Collection Fees)	0		9
10	Bad Debt Expense	0		10
11	Public Relations	0		11
12	Vending Machine Revenue	1,395	1	12
13	Adjust Physical Therapy cost to actual	0	10a	13
14	Management Fee Exp (Ic00)	(81,917)	17	14
15	Chamber of Commerce	(300)	20	15
16	Regional Public Relations	0	20	16
17	Royalty Fees (IC00)	0	20	17
18	Other Non-Oper Inc	0	21	18
19	Regional Marketing Director	0	21	19
20	Cable Tv	0	21	20
21	Discounts & Rebates	40	21	21
22	Franchise\Intangible T	0	21	22
23	RE Tax Accrual	180	33	23
24	Resident Expenses	(2,887)	27	24
25	Depreciation Expense - Equipment	16,598	30	25
26	Amortization - Leasehold Expense	17,553	30	26
27	Depr Exp Minor Durable Equipment	0	30	27
28	Barber/Beauty Inc	0	40	28
29	Patient Personal Services	0	21	29
30	Pat Personal Svcs Inc	0	21	30
31	Inconttinency Income	0	10	31
32	Equip Rental Income	0	35	32
33	Community Awareness	(5,074)	27	33
34	Special Events	0	20	34
35	Miscellaneous Exp (IC00)	0	27	35
36	Depr - Equipment (IC00)	0	27	36
37	Interest Expense - Interco (IC00)	2,804	32	37
38	FAS 121 Charge	0	21	38
39	Interest Expense - Net Assets	0	32	39
40	Adjust credit for prior period invoice	96	23	40
41	Pto Accrual Adjustment to Actual	47,248	22	41
42	Health Insurance	38,058	22	42
43	Worker's Compensation Audit Adjustment	0	22	43
44	Worker's Compensation Adjustment	43,559	22	44
45	Professional & General Liability Adjustment	(65,423)	26	45
46	Property Insurance Adjustment	329	26	46
47	Auto Insurance Adjustment	(716)	26	47
48	Interest Expense	(5,440)	32	48
49	**Total**	6,102		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SunBridge Care & Rehab - Effingham **#** 0042663 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	1,395	0	0	0	0	0	0	0	0	0	0	1,395	1
2	Food Purchase	(215)	0	0	0	0	0	0	0	0	0	0	(215)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	1,066	0	0	0	0	0	0	0	0	0	1,066	5
6	Maintenance	0	365	(5,472)	0	0	0	0	0	0	0	0	(5,107)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	1,180	1,431	(5,472)	0	0	0	0	0	0	0	0	(2,861)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	20	0	0	0	0	0	0	0	0	0	20	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	20	0	0	0	0	0	0	0	0	0	20	16
	C. General Administration													
17	Administrative	(81,917)	4,330	0	0	0	0	0	0	0	0	0	(77,587)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	6,874	0	0	0	0	0	0	0	0	0	6,874	19
20	Fees, Subscriptions & Promotions	(2,639)	397	0	0	0	0	0	0	0	0	0	(2,242)	20
21	Clerical & General Office Expenses	25	82,020	0	0	0	0	0	0	0	0	0	82,045	21
22	Employee Benefits & Payroll Taxes	128,864	10,215	0	0	0	0	0	0	0	0	0	139,079	22
23	Inservice Training & Education	96	0	0	0	0	0	0	0	0	0	0	96	23
24	Travel and Seminar	0	6,642	0	0	0	0	0	0	0	0	0	6,642	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(65,810)	2,362	0	0	0	0	0	0	0	0	0	(63,448)	26
27	Other (specify):*	9,568	0	0	0	0	0	0	0	0	0	0	9,568	27
28	**TOTAL General Administration**	(11,813)	112,840	0	0	0	0	0	0	0	0	0	101,027	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(10,633)	114,291	(5,472)	0	0	0	0	0	0	0	0	98,186	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SunBridge Care & Rehab - Effingham # 0042663 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	34,151	0	0	0	0	0	0	0	0	0	0	34,151	30
31	Amortization of Pre-Op. & Org.	0	10,117	0	0	0	0	0	0	0	0	0	10,117	31
32	Interest	(2,787)	0	10,976	0	0	0	0	0	0	0	0	8,189	32
33	Real Estate Taxes	180	0	0	0	0	0	0	0	0	0	0	180	33
34	Rent-Facility & Grounds	0	0	2,583	0	0	0	0	0	0	0	0	2,583	34
35	Rent-Equipment & Vehicles	0	0	5,720	0	0	0	0	0	0	0	0	5,720	35
36	Other (specify):*	0	11,044	888	0	0	0	0	0	0	0	0	11,932	36
37	**TOTAL Ownership**	31,545	21,161	20,167	0	0	0	0	0	0	0	0	72,873	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	20,911	135,452	14,695	0	0	0	0	0	0	0	0	171,058	45

Facility Name & ID Number SunBridge Care & Rehab - Effingham # 0042663 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SunBridge Healthcare Corp.	100%	Please see attached	Please see attached	See 6A	See 6A	See 6A

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Administrative	$	SunBridge Healthcare Corporation	100.00%	$ 4,330	$ 4,330	1
2	V	5	Heat and Other Utilities		SunBridge Healthcare Corporation	100.00%	1,066	1,066	2
3	V	6	Maintenance		SunBridge Healthcare Corporation	100.00%	365	365	3
4	V	14	Program Transportation		SunBridge Healthcare Corporation	100.00%	20	20	4
5	V	19	Legal & Accounting		SunBridge Healthcare Corporation	100.00%	6,874	6,874	5
6	V	20	Dues and Subscriptions		SunBridge Healthcare Corporation	100.00%	397	397	6
7	V	21	General Office Expenses		SunBridge Healthcare Corporation	100.00%	82,020	82,020	7
8	V	22	Employee Benefits		SunBridge Healthcare Corporation	100.00%	10,215	10,215	8
9	V	24	Travel		SunBridge Healthcare Corporation	100.00%	6,642	6,642	9
10	V	26	Insurance		SunBridge Healthcare Corporation	100.00%	2,362	2,362	10
11	V	36	Depreciation		SunBridge Healthcare Corporation	100.00%	11,044	11,044	11
12	V	31	Amortization		SunBridge Healthcare Corporation	100.00%	10,117	10,117	12
13	V								13
14	Total			$			$ 135,452	$ * 135,452	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SunBridge Care & Rehab - Effingham # 0042663 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		32	Interest	$	SunBridge Healthcare Corporation	100.00%	$ 10,976	$ 10,976	15
16	V		36	Property Taxes		SunBridge Healthcare Corporation	100.00%	888	888	16
17	V		34	Facility Lease		SunBridge Healthcare Corporation	100.00%	2,583	2,583	17
18	V		35	Equipment Lease		SunBridge Healthcare Corporation	100.00%	5,720	5,720	18
19	V		10	Pharmacy Expense	197,518	SunScript Pharmacy Corporation	100.00%	197,518		19
20	V		10a	Physical,Speech,Occupational Ther	346,030	SunDance Rehabilitation Corporation	100.00%	346,030		20
21	V		10a	Respiratory Therapy	2,674	SunCare Respiratory	100.00%	2,674		21
22	V		10	Medical Supplies & Equipment Rental	2,958	SunChoice Medical Supply	100.00%	2,958		22
23	V		6	Software	7,200	Shared Healthcare System, Inc.	70.40%	1,728	(5,472)	23
24	V		10	Medical Supplies & Equipment Rental	51,540	Medline Industries, Inc.	0.00%	51,540		24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 607,920			$ 622,615	$ * 14,695	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number SunBridge Care & Rehab - Effingham # 0042663 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SunBridge Care & Rehab - Effingham # 0042663 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Sun Healthcare Group Inc. (Corporate)
Street Address: 101 Sun Avenue NE
City / State / Zip Code: Albuquerque, NM 87109
Phone Number: (505) 468-4984
Fax Number: (505) 468-4969

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrative	Accumulated Cost	1,557,938,434	311	$ 1,692,927	$ 1,692,927	3,958,934	$ 4,302	1
2	5	Heat and Other Utilities	Accumulated Cost	1,557,938,434	311	387,282		3,958,934	984	2
3	6	Maintenance	Accumulated Cost	1,557,938,434	311	133,507		3,958,934	339	3
4	14	Program Transportation	Accumulated Cost	1,557,938,434	311	8,045		3,958,934	20	4
5	19	Legal & Accounting	Accumulated Cost	1,557,938,434	311	2,667,822		3,958,934	6,779	5
6	20	Dues and Subscriptions	Accumulated Cost	1,557,938,434	311	94,945		3,958,934	241	6
7	21	General Office Expenses	Accumulated Cost	1,557,938,434	311	25,594,615	19,078,284	3,958,934	65,039	7
8	22	Employee Benefits	Accumulated Cost	1,557,938,434	311	2,972,051		3,958,934	7,552	8
9	24	Travel	Accumulated Cost	1,557,938,434	311	1,503,862		3,958,934	3,822	9
10	26	Insurance	Accumulated Cost	1,557,938,434	311	923,577		3,958,934	2,347	10
11	36	Depreciation	Accumulated Cost	1,557,938,434	311	4,318,111		3,958,934	10,973	11
12	31	Amortization	Accumulated Cost	1,557,938,434	311	3,955,690		3,958,934	10,052	12
13	32	Interest	Accumulated Cost	1,557,938,434	311	4,291,770		3,958,934	10,906	13
14	36	Property Taxes	Accumulated Cost	1,557,938,434	311	346,868		3,958,934	881	14
15	34	Facility Lease	Accumulated Cost	1,557,938,434	311	588,958		3,958,934	1,497	15
16	35	Equipment Lease	Accumulated Cost	1,557,938,434	311	2,017,657		3,958,934	5,127	16
17										17
18										18
19		Total from attached Page 8a	Accumulated Cost	5,566					0	19
20		Total from attached Page 8b	Accumulated Cost	19,192					0	20
21										21
22										22
23			Total Units =							23
24			1,557,938,434							24
25	TOTALS					$ 51,497,687	$ 20,771,211		$ 130,861	25

Facility Name & ID Number SunBridge Care & Rehab - Effingham # 0042663 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Sun Healthcare Group Inc. (Corporate)
Street Address: 101 Sun Avenue NE
City / State / Zip Code: Albuquerque, NM 87109
Phone Number: (505) 468-4984
Fax Number: (505) 468-4969

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrative	Accumulated Cost	300,771,607	75	$ 464	$ 464	3,958,934	$ 6	1
2	5	Heat and Other Utilities	Accumulated Cost	300,771,607	75	104		3,958,934	1	2
3	6	Maintenance	Accumulated Cost	300,771,607	75	535		3,958,934	7	3
4	14	Program Transportation	Accumulated Cost	300,771,607	75	2		3,958,934		4
5	19	Legal & Accounting	Accumulated Cost	300,771,607	75	560		3,958,934	7	5
6	20	Dues and Subscriptions	Accumulated Cost	300,771,607	75	170		3,958,934	2	6
7	21	General Office Expenses	Accumulated Cost	300,771,607	75	276,688	172,279	3,958,934	3,642	7
8	22	Employee Benefits	Accumulated Cost	300,771,607	75	50,438		3,958,934	664	8
9	24	Travel	Accumulated Cost	300,771,607	75	55,683		3,958,934	733	9
10	26	Insurance	Accumulated Cost	300,771,607	75	253		3,958,934	3	10
11	36	Depreciation	Accumulated Cost	300,771,607	75	1,183		3,958,934	16	11
12	31	Amortization	Accumulated Cost	300,771,607	75	1,084		3,958,934	14	12
13	32	Interest	Accumulated Cost	300,771,607	75	1,176		3,958,934	15	13
14	36	Property Taxes	Accumulated Cost	300,771,607	75	247		3,958,934	3	14
15	34	Facility Lease	Accumulated Cost	300,771,607	75	26,276		3,958,934	346	15
16	35	Equipment Lease	Accumulated Cost	300,771,607	75	8,127		3,958,934	107	16
17										17
18										18
19										19
20										20
21			Total Units =							21
22			300,771,607							22
23										23
24										24
25	TOTALS					$ 422,990	$ 172,743		$ 5,566	25

Facility Name & ID Number SunBridge Care & Rehab - Effingham # 0042663 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Sun Healthcare Group Inc. (Corporate)
Street Address: 101 Sun Avenue NE
City / State / Zip Code: Albuquerque, NM 87109
Phone Number: (505) 468-4984
Fax Number: (505) 468-4969

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrative	Accumulated Cost	154,186,355	41	$ 844	$ 844	3,958,934	$ 22	1
2	5	Heat and Other Utilities	Accumulated Cost	154,186,355	41	3,158		3,958,934	81	2
3	6	Maintenance	Accumulated Cost	154,186,355	41	735		3,958,934	19	3
4	14	Program Transportation	Accumulated Cost	154,186,355	41	3		3,958,934		4
5	19	Legal & Accounting	Accumulated Cost	154,186,355	41	3,434		3,958,934	88	5
6	20	Dues and Subscriptions	Accumulated Cost	154,186,355	41	6,010		3,958,934	154	6
7	21	General Office Expenses	Accumulated Cost	154,186,355	41	519,488	401,422	3,958,934	13,339	7
8	22	Employee Benefits	Accumulated Cost	154,186,355	41	77,848		3,958,934	1,999	8
9	24	Travel	Accumulated Cost	154,186,355	41	81,286		3,958,934	2,087	9
10	26	Insurance	Accumulated Cost	154,186,355	41	461		3,958,934	12	10
11	36	Depreciation	Accumulated Cost	154,186,355	41	2,154		3,958,934	55	11
12	31	Amortization	Accumulated Cost	154,186,355	41	1,973		3,958,934	51	12
13	32	Interest	Accumulated Cost	154,186,355	41	2,140		3,958,934	55	13
14	36	Property Taxes	Accumulated Cost	154,186,355	41	173		3,958,934	4	14
15	34	Facility Lease	Accumulated Cost	154,186,355	41	28,835		3,958,934	740	15
16	35	Equipment Lease	Accumulated Cost	154,186,355	41	18,944		3,958,934	486	16
17										17
18										18
19										19
20			Total Units =							20
21			154,186,355							21
22										22
23										23
24										24
25	TOTALS					$ 747,486	$ 402,266		$ 19,192	25

Facility Name & ID Number SunBridge Care & Rehab - Effingham # 0042663 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Home Office Interest from Pages 8-8b										10,976	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 10,976	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 10,976	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number SunBridge Care & Rehab - Effingham **#** 0042663 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	26,520	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	26,700	2
3. Under or (over) accrual (line 2 minus line 1).	$	180	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	26,310	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	26,490	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996		8
1997	25,668	9
1998	25,965	10
1999	26,030	11
2000	26,700	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SunBridge Care & Rehab - Effingham COUNTY Effingham

FACILITY IDPH LICENSE NUMBER 0042663

CONTACT PERSON REGARDING THIS REPORT Sylvia Moreno

TELEPHONE (505) 468-4984 FAX #: (505)468-4969

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	03-11-017-031	1115 N. Wenthe	$ 26,700.36	$ 26,700.36
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 26,700.36	$ 26,700.36

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number SunBridge Care & Rehab - Effingham # 0042663 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,754 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number SunBridge Care & Rehab - Effingham # 0042663 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	INSTALL NURSES CALL/R.T.A SYS			1998	9,512						9
10	PVC PIPE BATHRMS/WNTE PLUMBING			1998	4,000						10
11	ELECTRIC WK-CABLING/RTA			1998	2,731						11
12	VINYL FLOOR P.T./WOHLTMAN CONS			1998	3,675						12
13	SLIDING WINDOW/K WOHLTMAN			1998	2,075	24,571	5-40	24,571		39,130	13
14	SIGN-EXTERIOR LOGO/ACME WILEY			1998	6,268						14
15	CABLING/G.E. CAPITAL			1998	5,173						15
16	ACT/REALITY/TODAY BOARDS/AGI			1998	2,560						16
17	P228-ASPHALT REPAVING			1998	55,837						17
18	CONCRETE PAD & DRAIN PIT/WALKER			1999	2,904						18
19	WATER LINES-WENTE			1999	2,622						19
20	Compressor			1999	835						20
21	WOOD FIRE DOOR			2000	514						21
22	drain lines replaced			2000	1,352						22
23	ROOF REPLACED			2000	42,170						23
24	PAINTING AND WALLPAPER P318			2001	61,248						24
25	FIXTURES P318			2001	38,098						25
26	Leasehold Improvements (15YR)			2001	5,022						26
27	METAL DOORS AND SHELVING P318			2001	5,568						27
28	WATER HEATER			2001	3,399						28
29	AC UNIT ROOFTOP			2001	5,051						29
30	VINYL WINDOW			2001	681						30
31	PLANTER BOXES			2001	3,019						31
32	SHOWER UNITS			2001	38,815						32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number SunBridge Care & Rehab - Effingham # 0042663 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Please See Attached Schedule		$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 303,129	$ 24,571		$ 24,571	$	$ 39,130	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SunBridge Care & Rehab - Effingham # 0042663 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 106,183	$ 14,961	$ 14,961	$		$ 52,549	71
72	Current Year Purchases	55,741	3,327	3,327			3,327	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 161,924	$ 18,288	$ 18,288	$		$ 55,876	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 465,053	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 42,859	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 42,859	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 95,006	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Effingham Associates L.L.C.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A	120	6/5/97	$ 503,139	10	10	3
4	Additions							4
5								5
6								6
7	TOTAL		120		$ 503,139 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 6/5/1997
Ending 6/30/1997

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2002	$ 455,360
13.	12/31/2003	$ 467,882
14.	12/31/2004	$ 479,579

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 15,118 Description: Please See Attached 14.1
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Errands	1995 Ford E250 Van	$ 449.07	$ 5,473	17
18					18
19					19
20					20
21	TOTAL		$ 449.07	$ 5,473	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SunBridge Care & Rehab - Effingham # 0042663 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number SunBridge Care & Rehab - Effingham # 0042663 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	Line 10a Col 3	mods	$	9,431	$ 127,316	$ 863	9,431	$ 128,179	1
2	Licensed Speech and Language Development Therapist	Line 10a Col 3	mods		5,656	76,354	450	5,656	76,804	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Line 10a Col 3	mods		10,467	141,308	609	10,467	141,917	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	Line 10 Col 2	# of prescrpts				168,195		168,195	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Respiratory Therapy Other (specify): IV Therapy & LALT	Line 10a Col 3				22,094	2,507		24,601	13
14	TOTAL			$	25,554	$ 367,072	$ 172,624	25,554	$ 539,696	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number SunBridge Care & Rehab - Effingham # 0042663 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 341,819	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	236,163		3
4	Supply Inventory (priced at)	15,188		4
5	Short-Term Investments			5
6	Prepaid Insurance	475		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Please See Attached			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 593,645	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	303,129		15
16	Equipment, at Historical Cost	161,924		16
17	Accumulated Depreciation (book methods)	(95,006)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Please See Attached	160,951		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 530,998	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,124,643	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ (43,598)	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	(22,881)		30
31	Accrued Taxes Payable (excluding real estate taxes)	(101,250)		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Please See Attached	(101,526)		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ (269,255)	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43		(1,911,792)		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ (1,911,792)	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (2,181,047)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,056,404	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (1,124,643)	$	48

***(See instructions.)**

Facility Name & ID Number SunBridge Care & Rehab - Effingham # 0042663 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,734,807	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,734,807	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	305,416	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Intercompany Eliminations**	(983,819)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (678,403)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,056,404	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number SunBridge Care & Rehab - Effingham # 0042663 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,451,555	1
2	Discounts and Allowances for all Levels	659,381	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,110,936	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	135,871	6
7	Oxygen	4,490	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 140,361	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	63,420	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	19,528	19
20	Radiology and X-Ray		20
21	Other Medical Services	7,648	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 90,596	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	151	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 151	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Please See Attached	1,422	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,422	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,343,466	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	569,408	31
32	Health Care	1,798,457	32
33	General Administration	1,023,842	33
	B. Capital Expense		
34	Ownership	562,030	34
	C. Ancillary Expense		
35	Special Cost Centers	84,313	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,038,050	40
41	**Income before Income Taxes (line 30 minus line 40)****	305,416	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 305,416	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SunBridge Care & Rehab - Effingham # 0042663 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,890	1,875	$ 56,459	$ 30.12	1
2	Assistant Director of Nursing	192	277	5,272	19.00	2
3	Registered Nurses	18,366	18,445	315,960	17.13	3
4	Licensed Practical Nurses	12,484	12,391	179,217	14.46	4
5	Nurse Aides & Orderlies	52,776	55,883	494,260	8.84	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides				12.00	8
9	Activity Director	1,723	1,756	21,072	8.75	9
10	Activity Assistants	1,942	2,023	17,700	10.36	10
11	Social Service Workers	3,499	3,586	37,141	11.25	11
12	Dietician	208	308	3,463	11.00	12
13	Food Service Supervisor	1,640	1,653	18,188		13
14	Head Cook				6.98	14
15	Cook Helpers/Assistants	12,764	13,140	91,735		15
16	Dishwashers				11.98	16
17	Maintenance Workers	2,299	2,405	28,805	7.38	17
18	Housekeepers	8,642	8,640	63,752	6.51	18
19	Laundry	4,872	5,252	34,208	30.04	19
20	Administrator	1,808	1,666	50,052		20
21	Assistant Administrator			693	11.25	21
22	Other Administrative	5,004	5,087	57,235	15.63	22
23	Office Manager	307	277	4,332		23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)				13.44	30
31	Medical Records	4,332	4,309	57,889		31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	134,746	138,973	$ 1,537,432 *	$ 11.06	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	419	$ 14,648	1.3	35
36	Medical Director	Mthly Fee	9,700	9.1	36
37	Medical Records Consultant	12	3,005	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	17	7,200	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	131	6,196	10.3	45
46	Other(specify) A&G Consulting Fees	7	671	19.3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	586	$ 41,420		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number SunBridge Care & Rehab - Effingham # 0042663 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Shirley Dunn	Administrator	0	$ 49,931
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 49,931

B. Administrative - Other

Description	Amount
Management Fees	$ 81,917
Regional Allocation	87,883
TOTAL (agree to Schedule V, line 17, col. 3)	$ 169,800
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Sentry Plus	SB Name Badges	$ 180
Esparza King	Design of Strategic Plan	38
Eproperty Tax	Real & Personal Prop Tax Info	100
Rick Johnson & CO	Advertising	38
Maun Lemke Inc.	Consultant Fees	671
No Legal Fees		
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 1,027

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Home Office Employee Benefits	10,214
TOTAL (agree to Schedule V, line 22, col.8)	$ 10,214

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,203
Health Care Worker Background Check	
(Indicate # of checks performed)	
Chamber of Commerce\Shirley Dunn	475
IL Health Care Assoc\Bank Svc Charges	6,370
H.O. Dues & Subs\Notary Public\Kiwanis	534
Social Svc Prof.\Effingham Daily News	163
Creative Forecating\Old Republic Surety	73
Less:Chamber\Reg Pen&Late\Comm Aware	(2,639)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,179

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 1,745
In-State Travel	6,208
Home Office Travel	6,642
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,595

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SunBridge Care & Rehab - Effingham # 0042663 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number SunBridge Care & Rehab - Effingham **#** 0042663 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Healthcare Assoc. $5770**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,047** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **65,720**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Arthur Andersen & Co** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Financial Statements are consolidated**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

03.01.01.	113387	53202	0	166589
03.01.02.	13212	0	0	13212
03.01.03.	14648	0	0	14648
03.01.05.	0	0	0	0
03.02.02.	131617	19	1180	132815
03.03.01.	63752	29913	0	93665
03.03.02.	10162	0	0	10162
03.03.03.	107948	0	0	107948
03.04.01.	34208	16051	0	50259
03.04.02.	10714	0	0	10714
03.04.03.	219	0	0	219
03.06.01.	28805	13516	0	42321
03.06.02.	11383	0	0	11383
03.06.03.	29353	0	0	29353
03.07.03.	0	0	0	0
03.09.01.	0	0	0	0
03.09.03.	9654	-22	0	9633
03.10.01.	1076275	506011	0	1582285
03.10.02.	190922	0	0	190922
03.10.03.	64887	0	0	64887
03.10.05.	0	0	0	0
03.10.a.01	0	0	0	0
03.10.a.02	4445	0	0	4445
03.10.a.03	367073	0	0	367073
03.11.01.	38772	18192	0	56964
03.11.02.	2960	0	0	2960
03.11.03.	0	0	0	0
03.12.01.	37141	17427	0	54567
03.12.02.	132	0	0	132
03.12.03.	6196	0	0	6196
03.13.03.	0	0	0	0
03.14.03.	0	0	0	0
03.15.03.	0	0	0	0
03.17.01.	49931	23428	0	73359
03.17.03.	169800	-599	-84451	84750
03.18.03.	0	0	0	0
03.19.03.	1027	0	0	1027
03.20.03.	9421	0	-300	9121
03.21.01.	95161	43637	0	138798
03.21.02.	9524	0	0	9524
03.21.03.	29770	0	40	29810
03.22.03.	592489	-721354	128864	0
03.23.03.	325	-19	96	403
03.24.03.	7953	0	0	7953
03.26.03.	68203	0	-65810	2393
03.27.03.	-9762	0	9762	0
04.30.03.	8708	0	34151	42859
04.31.03.	0	0	0	0
04.32.03.	2787	0	-2787	0
04.33.03.	26310	0	180	26490
04.34.03.	503139	0	0	503139
04.34.05.	0	0	0	0
04.35.03.	20591	0	0	20591
04.35.05.	0	598	0	599
04.36.03.	495	0	0	495
04.38.03.	24	0	0	24
04.39.03.	0	0	0	0
04.40.02.	0	0	0	0
04.40.03.	0	0	0	0
04.41.03.	0	0	0	0
04.42.03.	74720	0	0	74720
04.43.02.	3956	0	0	3956
04.43.03.	5613	0	0	5613
17.01.	341819	0	0	341819
17.03.	236163	0	0	236163
17.04.	15188	0	0	15188
17.06.	475	0	0	475
17.07.	0	0	0	0
17.13.	0	0	0	0
17.14.	0	0	0	0
17.15.	51432	0	251697	303129
17.16.	12527	0	149397	161924
17.17.	-8708	0	-86298	-95006
17.19.	0	0	0	0
17.20.	0	0	0	0
17.22.	0	0	0	0
17.23.	160951	0	0	160951
17.26.	-43598	0	0	-43598
17.30.	-22881	0	0	-22881
17.31.	-101250	0	0	-101250
17.32.	0	0	0	0
17.36.	-101526	0	0	-101526
17.39.	0	0	0	0
17.43.	-1911792	0	0	-1911792
17.44.	0	0	0	0
17.47.	1676621	0	0	1676621
19.01.	-3451555	0	0	-3451555
19.02.	-659381	0	0	-659381
19.06.	-135871	0	0	-135871
19.07.	-4490	0	0	-4490
19.13.	0	0	0	0
19.14.	0	0	0	0
19.17.	-63420	0	0	-63420
19.19.	-19528	0	0	-19528
19.20.	0	0	0	0
19.21.	-7648	0	0	-7648
19.22.	0	0	0	0
19.25.	-151	0	0	-151
19.28.	-1422	0	0	-1422
19.28.a.	0	0	0	0